Business Name: _____ KEIN: _____

For Office of Insurance Use Only-
Date: _____
Initial:_____
ICARE ID# _____

P.O. Box 495
46 Mill Creek Park
Frankfort, KY 40602
(877) 422-7307
http://icare.ky.gov

Kentucky Office of Insurance
ICARE Program Application

To provide accurate responses and avoid delays in processing your application, it is highly recommended that you carefully read all instructions prior to completing this application. To obtain a copy of the instructions, visit our Web site at http://icare.ky.gov or call (877) ICARE07.

ALL FIELDS MUST BE COMPLETED IN ORDER FOR YOUR APPLICATION TO BE CONSIDERED.

Section 1 – Employer Information

Business Name			
Entity Type	KEIN (9-Digits)		SIC (4-Digits)
Business Address Line 1	Business Address Line 2		
City	State **KY**	Zip Code	

Mailing Address for ICARE health care incentive payment (if different from above)

Address	City	State **KY**	Zip Code
Contact Person	E-Mail Address	Telephone Number	

1. Name(s) of all individuals with an "ownership interest" in your business: _____
_____
_____.
2. Number of individuals employed by your business: _____.
3. Number of ICARE eligible employees who have enrolled in the employer-sponsored Qualified Health Benefit Plan: _____. (See Required Attachments 2 & 3).
4. Did you provide health insurance for your employees in the twelve (12) months prior to your current Qualified Health Benefit Plan coverage? ☐Yes ☐No
5. Name of Insurer providing health insurance coverage for the ICARE Program Year: _____ (See Required Attachment 1).
6. Name of Qualified Health Benefit Plan(s) (**Previously uninsured groups with enriched plans will not qualify for the ICARE Program**): _____.
_____(See Required Attachment 3).
7. Provide the Qualified Health Benefit Plan effective date _____/_____/_____ (mm/dd/yyyy).
8. Did you obtain your insurance through an Employer-Organized Association (EOA)? ☐No ☐Yes (If Yes, provide EOA name) _____.

Section 2 – Employer Attestation

By signing below, the employer attests to the following:

1. The principal office of the business is located in Kentucky;
2. At time of this application, the average gross annual salary of the employer group, excluding any employee who: (a) has attained age 65, (b) is Medicare eligible, (c) does not meet eligibility requirements for participation in the employer-sponsored health benefit plan established by the employer and insurer, or (d) has an ownership interest in the business, is less than or equal to 300% of Federal Poverty Level for a family of three (Attach supporting documentation); and
3. One or more eligible employees are Kentucky residents.

Furthermore, the employer agrees to comply with the following:

1. Maintain confidentiality of all employee data in accordance with privacy standards set forth in state and federal law;
2. Pay no less than 50% of the single premium cost of the Qualified Health Benefit Plan coverage each enrolled employee;
3. Respond within 15 business days to any inquiry from the Office of Insurance relating to the employer's participation or application in the ICARE Program; and
4. Allow, upon request, a review by the Office of Insurance of all business records relating to ICARE Program participation retained by the employer.

Information contained in or attached to this application is accurate and complete to the best of my knowledge. Any misrepresentation, misstatement, or omission, whether intentional or not, may constitute cause for immediate rejection of this application and termination from the ICARE Program.

Any person who knowingly and with intent to defraud the ICARE Program or other person files an application for ICARE containing materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Employer Signature: _____ Date:_____

Employer Name (Print): _____ Title:_____

Required Attachments:

1. A copy of the Employer Application for coverage to the insurer (if the application is unavailable, renewal documentation may be attached in lieu of the employer application);
2. Documentation relating to the employer group's gross annual salary for the most recent twelve (12) months (e.g., four (4) most recent complete Kentucky Employer's Quarterly Unemployment Tax Worksheet {Form UI3} filed with KY Division of Unemployment Insurance or if unavailable, payroll register);
3. Documentation verifying the employer's enrollment in a Qualified Health Benefit Plan, including the name of the employer group, Qualified Health Benefit Plan name, insurer name and effective date of coverage;
4. Employee's ICARE High Cost Condition Certification, if applicable; and
5. Any additional attachments necessary to respond to the questions in the application.

Business Name: _____ KEIN: _____

Section 3 – Agent Verification

1. This group qualifies for the ICARE Program based upon (check only one):
   ☐ High-Cost Condition (Attach HCC certification) ☐ Previously Uninsured

2. The group identification number assigned to this employer by the insurer is as follows:

_____.

The employer has submitted all required information to support eligibility for the ICARE Program. By signing below, I acknowledge and certify that I, the agent, have reviewed the supporting documentation and to the best of my knowledge this employer meets the eligibility requirements as specified in this application. (See required attachments.)

Any person who knowingly and with intent to defraud the ICARE Program or other person files an application for ICARE containing materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Agent Signature: _____ Date:_____

Agent Name (Print): _____ DOI No.:_____

Submit the original ICARE Program application and all required attachments to:

US Mail:

ICARE Program
P.O. Box 495
Frankfort, KY 40602

Overnight or Express Delivery:

ICARE Program
46 Mill Creek Park
Frankfort, KY 40601

Faxed or e-mailed applications will not be accepted.

Business Name: _____ KEIN: _____

Employee Information

Complete the following information for each employee.

	Employee Name (First, MI, Last)	Birth Date (mm/dd/yy)	Hire Date (mm/dd/yy)	Enrolled in the Business's Health Plan? (Yes, Not Eligible, or Waived)	Medicare Eligible? (Yes or No)	Average Number of Hours Worked Per Week
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						
12.						
13.						
14.						
15.						
16.						
17.						

Business Name: _____ KEIN: _____

	Employee Name (First, MI, Last)	Birth Date (mm/dd/yy)	Hire Date (mm/dd/yy)	Enrolled in the Business's Health Plan? (Yes, Not Eligible, or Waived)	Medicare Eligible? (Yes or No)	Average Number of Hours Worked Per Week
18.						
19.						
20.						
21.						
22.						
23.						
24.						
25.						
26.						
27.						
28.						
29.						
30.						
31.						
32.						
33.						
34.						
35.						

Business Name: _____ KEIN: _____

Employee ICARE Program High-Cost Condition Certification

No	Yes	Medical Condition
☐	☐	Anoxic brain injury, which shall be limited to anoxic brain injury associated with drowning and nonfatal submersion or Intrauterine hypoxia and birth asphyxia
☐	☐	Ascites
☐	☐	Back disorder, limited to lumbar or lumbosacral disc degeneration and lumbar disc displacement
☐	☐	Brain tumor
☐	☐	Burn, limited to full-thickness skin loss involving ten (10) percent or more of body surface
☐	☐	Cancer, limited to Ewing's sarcoma, Hodgkin's disease, leukemia, lymphoid leukemia, malignant neoplasm of breast, metastatic cancer, myeloid leukemia, or primary cancer
☐	☐	Cirrhosis of the liver
☐	☐	Endocrine disorder, limited to insulin dependent diabetes mellitus or inherited metabolic diseases as established in KRS 205.560(1)(c) (see agent for list)
☐	☐	Heart condition, limited to acute myocardial infarction, angina pectoris, cardiac valve disorders, cardiomyopathy, congenital cardiac anomalies, coronary insufficiency, coronary occlusion, heart failure, injury to heart and lung, ischemic heart disease, pulmonary atresia, pulmonary hypertension, or status post open-heart surgery
☐	☐	Hemophilia
☐	☐	Hypersomnia with sleep apnea
☐	☐	Lung condition, limited to chronic airway obstruction, diseases of the lung, or post inflammatory pulmonary fibrosis
☐	☐	Kidney condition, limited to chronic renal failure, end stage renal disease, or polycystic kidney
☐	☐	Morbid obesity
☐	☐	Multiple sclerosis
☐	☐	Organ or tissue replaced by transplant
☐	☐	Psychotic disorder
☐	☐	Rhabdomyolysis
☐	☐	Stroke
☐	☐	Trauma, limited to fracture or complete lesion of cord, or multiple trauma

I certify that I have been diagnosed or treated by a health care provider legally authorized to diagnose the medical condition identified above within the past five (5) years. This diagnosis has been documented in my medical record.

Signature:_____ Date: _____

Name (Print): _____